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TRICARE
MANAGEMENT ACTIVITY

MB&RS

CHANGE 59
6010.55-M
MAY 7, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to the 6010.55-M, issued August 2002.

CHANGE TITLE: INCREASE IN PAYMENTS FOR MENTAL HEALTH
SERVICES OF CERTIFIED PSYCHIATRIC NURSE
SPECIALISTS

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change is to raise allowable amounts for mental
health services rendered by Certified Psychiatric Nurse Specialists to 85 percent of
the allowable amount of a physician.

EFFECTIVE AND IMPLEMENTATION DATE: June 1, 2007.

A handwritten signature in black ink, appearing to read "Reta Michak".

Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Systems

ATTACHMENT(S): 14 PAGE(S)
DISTRIBUTION: 6010.55-M

CHANGE 59
6010.55-M
MAY 7, 2007

REMOVE PAGE(S)

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CHAPTER 1 - GENERAL

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REIMBURSEMENT OF PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CERTIFIED PSYCHIATRIC NURSE SPECIALISTS

ISSUE DATE: July 9, 1990

AUTHORITY: 32 CFR 199.14(j)(1)(x)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

How are Physician Assistant (PA), and Nurse Practitioner (NP), and Certified Psychiatric Nurse Specialists (CPNS) services to be reimbursed?

III. POLICY

A. The allowable charge for the services of the above listed providers may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician. The employing physician of a PA must be an authorized TRICARE provider.

1. When the employing physician of a PA is not participating in a TRICARE/CHAMPUS reimbursement plan at less than the allowable charge determined under the provisions of Chapter 1, Section 1, the allowable charge for the PA service may not exceed 85 percent of the allowable charge for the physician calculated in accordance with these provisions. When the PA and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit components), the allowable charge for the procedure (to include both the services of the physician and PA) may not exceed the allowable charge for the procedure rendered by a physician.

2. When the employing physician is participating in a TRICARE/CHAMPUS reimbursement plan at less than the allowable charge as calculated in paragraph III.A.1. above, the allowable charge for the PA service may not exceed 85 percent of the reduced allowable charge for the physician unless the reimbursement plan has specifically included use of PAs in the negotiated rates.

B. The allowable charge for PA and NP services performed as an assistant-at-surgery may not exceed 85 percent of the allowable charge for a physician serving as an assistant

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surgeon when authorized as TRICARE/CHAMPUS benefits in accordance with the provisions of 32 CFR 199.4(c)(3)(iii), and subject to the procedures for calculation contained in paragraph III.A.1. and paragraph III.A.2. above.

C. The procedure or service performed by the PA is billed by the supervising or employing physician, billing it as a separately identified line item (e.g., PA Office Visit) and accompanied by the assigned PA provider number.

D. The procedure or service performed by the NP or CPNS is billed by the NP or CPNS. Unlike a PA, a NP or CPNS can bill on their own behalf. Like the PA, the NP or CPNS shall bill using an assigned NP or CPNS provider number.

IV. EFFECTIVE DATES

A. Reimbursement of PA services is effective for services rendered on or after July 1, 1990.

B. Reimbursement of NP services as stated above is effective for services rendered on or after September 1, 2003.

C. Reimbursement of CPNS services shall be 85 percent of the allowable amounts for physicians effective for services rendered on or after June 1, 2007.

- END -

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CHAPTER 5, SECTION 3

ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

D. The CHAMPUS Maximum Allowable Charge applies to all fifty states, Puerto Rico, and the Philippines. Further information regarding the reimbursement of professional services in the Philippines, see the TRICARE Policy Manual, Chapter 12, Section 11.1. Guam and the Virgin Islands are to still be paid as billed for professional services.

E. Provisions which affect the TRICARE allowable charge payment methodology.

NOTE: The first CMAC file update for 1999, raises all CMACs for physicians and psychologists that are priced using the Medicare RVUs to the Medicare Fee Schedule levels. CMACs for mental health providers (clinical social workers, certified marriage and family therapists, and pastoral and mental health counselors under a physician's supervision) shall be reduced by 15 percent in 1999 and a further 10 percent in 2000 so that they will be equal to 75 percent of the CMAC for psychiatrists and psychologists by the year 2000. Medicare reimburses these providers at the same differential.

Effective for services provided on or after September 1, 2003, the payment for certain provider changes to the physician payment level. These providers include: podiatrists, oral surgeons, optometrists, occupational therapists, speech therapists, physical therapists, audiologists, and psychologists. Previously, psychologists were paid under the physician payment level, and the above remaining providers were paid under the non-physician payment level. Podiatrists, oral surgeons, and optometrists shall also come under the HPSA bonus payment. See Chapter 1, Section 33.

1. Reductions in maximum allowable payments to Medicare levels.
2. Balance billing limitation.

α. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. This limit is 115 percent of the TRICARE allowable charge, not to exceed the billed charge.

NOTE: When the billed amount is less than 115 percent of the allowed amount, the provider is limited to billing the billed charge to the beneficiary. The balance billing limit is to be applied to each line item on a claim.

EXAMPLE 1:	No Other Health Insurance	
	Billed charge	\$500
	Allowable charge	\$200
	Amount billed to beneficiary (115% of \$200)	\$230

EXAMPLE 2:	Other Health Insurance	
	Billed charge	\$500
	Allowable charge	\$200
	Amount paid by other health insurance to the beneficiary	\$200
	Amount billable to beneficiary (115% of \$200)	\$230

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ALLOWABLE CHARGES - CHAMPUS MAXIMUM ALLOWABLE CHARGES (CMAC)

NOTE: When payment is made by other health insurance, this payment does not affect the amount billable to the beneficiary by the nonparticipating provider except, when it can be determined that the other health insurance limits the amount that can be billed to the beneficiary by the provider.

b. Failure to Comply. If a nonparticipating provider fails to comply with this balance billing limitation requirement, the provider shall be subject to exclusion from the TRICARE Program as an authorized provider and may be excluded as a Medicare provider.

c. Granting of Waiver of Limitation. When requested by a TRICARE beneficiary, the contractor, on a case-by-case basis, may waive the balance billing limitation. If the beneficiary is willing to pay the nonparticipating provider for his/her billed charges, then the waiver shall be granted. The contractor shall obtain a signed statement from the beneficiary stating that he/she is aware that the provider is billing above the 115 percent limit, however, they feel strongly about using that provider and they are willing to pay the additional money. The beneficiary shall be advised that the provider still may be excluded from the TRICARE program, if he/she is over billing other TRICARE beneficiaries and they object. The waiver is controlled by the contractor, not by the provider. The contractor is responsible for communicating the potential costs to the beneficiary if the waiver statement is signed. A decision by the contractor to waive or not to waive the limit is not subject to the appeals process. For the TRICARE Outpatient Prospective Payment System (OPPS), the granting of waivers for balance billing limitations applies only to EXEMPT OPPS providers.

3. Site of Service. CMAC payments based on site of service becomes effective for services rendered on or after April 1, 2005. Payment based on site of service is a concept used by Medicare to distinguish between services rendered in a facility setting as opposed to a non-facility setting. Prior to April 1, 2005, CMACs were established at the higher rate of the facility or non-facility payment level. For some services such as radiology and laboratory tests, the facility and non-facility payment levels are the same. In addition, prior to April 1, 2005, CMAC pricing was established by class of provider (1, 2, 3, and 4). These four classes of providers will be superseded by four categories.

a. Categories.

Category 1: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists provided in a facility including hospitals (both inpatient and outpatient where the hospital is generating a revenue bill, i.e., revenue code 510), residential treatment centers, ambulances, hospices, military treatment facilities, psychiatric facilities, community mental health centers, skilled nursing facilities, ambulatory surgical centers, etc.

Category 2: Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists provided in a non-facility including provider offices, home settings, and all other non-facility settings.

Category 3: Services, of all other providers not found in category 1, provided in a facility including hospitals (both inpatient and outpatient where the hospital is generating a revenue bill, i.e., revenue code 510), residential treatment centers, ambulances,

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